Electronic Documentation of Medical Readiness—What is the System of Record?

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Agenda

- Statement of Problem
- Current State
- Challenges/Impacts
- Examples
- Recommendations for Action
- Discussion/Questions

Statement of Problem

- In the continued GWOT environment there is a mismatch between Army policy and operational reality in terms of supporting the medical readiness needs of Soldiers.

- This leads to medical readiness data inconsistencies, redundant work efforts, confusion and frustration for clinical and operational leaders, as well as Soldiers.

Current State—AHLTA

Slide 1 of 2

- Immunization Module Available But Not All Sites Using It (Many Improvements Can Be Made)
- Build 838 Contains Army Readiness Graphical User Interface
- Pending AHLTA CDR/MEDPROS Interface
- Pending Immunization Bi-Directional Interface (IBDI)
- Awaiting Full Implementation of Remote Access Solution

Current State—AHLTA

- Reporting via CDM Not Robust
- Air Force and Navy Interested in Enhanced Readiness Documentation
- Ability To Capture Workload if Full Encounter Documented
- PDHRA Not Available in Build 838 (Scheduled for Build 843)
- PHA Not Available in Build 838

Current State—MEDPROS

- Most Readiness Policy Refers to MEDPROS as the System of Record
- Operational Focus
- Reporting Available Which Supports the Operational Commander
- Linked To AKO For Soldier Notification
- Accessed via World Wide Web

Current State—MEDPROS

- Pending AHLTA CDR/MEDPROS Interface
- Pending Immunization Bi-Directional Interface (IBDI)
- No Connection With Clinical Data
- No Capture of Workload
- Only Connection With Navy and Air Force is Through AMSA

Current State—DARTS

- Deployment And Reconstitution Tracking Software (DARTS) Aimed at Monitoring Reserve Component Deployment Readiness
- Only Approved Interface for Medical Readiness Data is MEDPROS
- Changes Not Fully Coordinated With AHLTA

Current State—Paper

- Most (If Not All) SRP Sites Still Maintain Some Type of Paper Record
- Policies Still State “Copy of DDXXX Must Be Placed in Soldier’s Record.”
- Utilization of Paper Allows for Capture of Workload in CHCS Legacy After SRP Activity Concludes
- Leaves Room For Error in Documentation of SRP Actions
- Challenges With Storage and Management of Paper Artifacts

Challenges/Impacts

- Tri-Service Medical Readiness Processing Requirement
  - Difficult Technically and Functionally to Conduct Tri-Service Medical Readiness Processing
  - Multiple Groups Working Readiness Issues, But Not Coordinated
  - Easier To Work Unilaterally, But Won’t Get Us To Ultimate Goal
  - Navy Now Contracting To Build AHLTA Readiness Functionality

Challenges/Impacts

- Reporting—Operational vs. Clinical—MEDPROS vs. CDM (Tri-Service Capability)
  - Operational and Clinical Commanders Do Not Have Clear Medical Readiness Picture
- Connectivity, Reliability and Speed of Systems
  - Difficult to Maintain Throughput and Accurate Documentation at Large SRP Sites
  - Data Inconsistency
  - Impact Somewhat Mitigated With Web Access and/or If SRP Site is On MTF Network

Challenges/Impacts

- Full Medical History Not Available in MEDPROS for Clinical Decision Making
  - Negative Patient Safety Implications
  - Possible Incorrect Clinical Decisions
  - Does Not Allow For Appropriate Integration of Decision Support Tools
- Healthcare Provider Staffing
  - Current Staffing at SRP Sites and Clinics Can Not Support Ongoing Redundant Data Entry
  - Technical Solutions Must Support Current Workload/Staffing Models

Challenges/Impacts

- Personal Health Information in Non-Clinical System
  - Possible HIPAA Violations
  - Blurring Lines Between “Operational Need To Know” and “Clinical Need To Know”
- Multiple Contract Groups Working Various Areas of Medical Readiness Documentation
  - Difficult to Coordinate ONE Solution For Documenting Medical Readiness Information

Challenges/Impacts

- Medical Readiness Requirements for Non-Soldiers
  - Difficult to Document Medical Readiness Data for Non-Government Civilians Processing Through SRP Sites
- Reserve and National Guard Access to AHLTA and Implementation of EHR
  - Disconnect Between Active/Reserve/National Guard Medical Readiness Documentation
- Budget
  - Building Two Parallel Systems Is Not Cost Efficient

Examples

- Documentation of Physicals and PHA
- PDHRA Clinical Data Not Available in AHLTA
- Profiles
  - Can Not Rely on PULHES Alone
  - Limited Duty vs. Deployment Restricted
  - Multiple Temporary and Permanent
  - Operational Leaders Want to Know Estimated Date of Return to Full Duty
- Need for USNORTHCOM Commander to Know Medical Readiness Status of Tri-Service Personnel

Recommendations for Action

Slide 1 of 2

- Appoint Army POC to Lead Medical Readiness Documentation and Reporting Transformation
- Empower Army POC to Work with AF/Navy Representatives and TMA IM Requirements Managers to Ensure One View is Forwarded for Development/Deployment Within Our Clinical Systems
- Formalize the Medical Readiness Decision-Making Body to Support the Army POC
- Define and Publish a Cohesive Policy That Matches Current Operational Reality Then Train/Implement to That Standard
  - AHLTA As Source System for All Data Input and All Clinical Reporting
  - Utilize MEDPROS for All Operational Data Reporting

Recommendations for Action

Slide 2 of 2

- Change DARTS Medical Readiness Source System to AHLTA
- Tri-Service Determination of Appropriate Operational and Clinical Reporting Requirements That Will Lead To Improved Medical Readiness Outcomes
- Improve Profile/Limited Duty Chit Process To Better Reflect Non-Deployability and Estimated Date of Return to Full Duty

Conclusion

- Identify an Army POC and Support Team to Tackle Medical Readiness Documentation Issues
- Implement and Document Policy and Guidance to Institutionalize a Culture of Readiness by Requiring a Single Source System for Medical Readiness Documentation That Supports Operational Requirements

Discussion/Questions